WASHBURN UNIVERSITY
Affidavit of Licensed Health Care Provider

Student Name _____

Relevant semester (dates) _____

By my signature on this document, I grant permission to my health care provider to release the medical information pertinent to my petition for withdrawal from Washburn University.

Student Signature _____ Date _____

Health Care Provider information:

I, _____ the undersigned, being first duly sworn on my oath, depose and say:

I) I am a health care provider duly licensed by the proper governing board for the licensure of health care providers in the state in which I practice.

2) That the above named student is/was a patient under my treatment or care

From _____ to _____ (dates)

3) That the above named student first sought treatment on _____ (date) for the medical situation described below.

Licensed Health Care Provider Information:

Signature _____ Date _____

Address _____

Phone _____

Please insert a description of the illness/injury in the space provided below. The description should be such that the severity of the illness/injury is made evident and should explain why the student was unable to successfully complete the semester/session in question (noted above). If additional space is required, it may be written on your letterhead and appended to this form.